Gasior Declaration

Exhibit H-154-5

EXHIBIT E

Other than the $25 annual cap for co-payments on dental services, Family Health Plus has no other cap on co-payments. Family Health Plus plans will be responsible for the implementation of applicable co-payments and tracking the annual dental cap.

The FHPlus recipient should be reimbursed the difference between the co-pay paid and the FHPlus co-payment schedule amounts. If there is a co-pay for a service for which there is no corresponding FHPlus co-pay, we would reimburse the whole amount.

Vision Benefits
Currently, the Family Health Plus vision benefit is similar to the Medicaid vision benefit. The Family Health Plus vision benefit will cover the following once every 2 years: 1) one eye exam; 2) either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses where medically necessary; and 3) one pair of medically necessary occupational eyeglasses. Lost eyeglasses are no longer a covered benefit.

45. Q: What is the difference between coinsurance and co-payment?

A: Having a health plan that includes a coinsurance, or percentage participation rate, means that the member and insurance carrier each pay a specified percentage of the healthcare cost.

For instance, if the health plan has an 80/20 coinsurance rate, the insurance plan pays for 80% of the eligible medical expense and the member is responsible for the remaining 20%. A co-payment, on the other hand, is a fixed dollar amount ($5.00 for example) that the member is required to pay regardless of the cost of the service received.

To compensate for the possibility that a catastrophic medical loss could cause a member severe financial distress, many major health insurance carriers include what is known as a "coinsurance cap", or stop-loss limit in their plans. The provision sets limits on the member's potential out-of-pocket costs per year. Such caps generally range from $2,000 to $3,000, depending on the plan, but limits can be as low as $1,000.

46. Q: Who will the district pay the premium payments to?

A: Premium payments can be made to the applicant, the employer or the carrier as arranged with the payee. Per 08 OHIP/ADM-1, Upstate district are instructed to make payments via the Benefit Issue Control System (BICS).

47. Q: Who is responsible to pay the co-pays, coinsurance and deductibles?

A: The recipient pays the co-payments, coinsurance and deductibles and brings the receipt into LDSS for reimbursement.

48. Q: Can an individual with FHP-PAP refuse to pay a co-pay, for example at the pharmacy, and still receive their prescription?

A: If the recipient is using the New York State Benefit Identification card (because drugs are not included in the ESI) to obtain prescriptions, the recipient may refuse to pay the co-pay per current Medicaid rules. If the individual is using the ESI commercial insurance card, she/he may not refuse to pay the co-pay. The district will reimburse the recipient for the co-pay paid minus the FHPlus co-pay amount.

49. Q: Is there a hardship provision if the member says they cannot pay the co-pays and deductibles up front for services?
A: There is no hardship provision in the FHP-PAP legislation.

50. Q: When the commercial policy has a co-payment that is greater than the FHPlus co-payment, how much should the district reimburse the member?
A: The member pays the ESI co-payment to the provider. The district reimburses the member the ESI co-pay amount minus any applicable FHPlus co-pay amount.

51. Q: If a member requests cash to pay a co-pay prior to seeing a provider should the district authorize payment prior to the appointment?
A: No, only paid receipts may be submitted to the district for reimbursement.

52. Q: Will this program reimburse coinsurance, deductibles, and/or co-pays for benefits which are not provided by FHPlus even though they are provided by the ESI?
A: No. We will not pay or reimburse for a service not otherwise covered by Family Health Plus.

53. Q: If a member goes out of network for a service that is provided under the employer's plan (it is also a service covered under FHPlus), and the member pays cash for it, can the district deny reimbursement because the member went out of network?
A: The member may be reimbursed, but must present an Explanation of Benefits (EOB) from the plan showing the amount the plan paid towards the claim. The reimbursement would equal the amount which would not be paid by the plan minus the FHPlus co-payment.

54. Q: If a member goes for a non-FHPlus benefit, such as chiropractor, is the member entitled to reimbursement for a co-payment paid?
A: No. We will not pay or reimburse for a service not otherwise covered by Family Health Plus.

55. Q: Is reimbursement required to a recipient who does not use their own ESI provider, or a Medicaid provider? Or will it be a patient "out of pocket" expense? Is Payment Type code U4 used in this instance? At what rate is the claim reimbursed?
A: There may be times when a service is not covered under the employer's policy and the recipient used a non-Medicaid provider for a benefit that would otherwise be covered by FHPlus. The recipient would have to provide the LDSS with an Explanation of Benefits (EOB) showing the claim was denied by the employer plan. In these instances the recipient can be reimbursed for payment made, minus the FHPlus co-payment amount for the service. U4 is the BICS pay type to be used.

56. Q: Can the district tell the recipient they have a limited time to bring in receipts for reimbursement?
A: No. However, recipient education is key. Advise them to bring in receipts in a timely manner. Local districts are also required to process reimbursements in a timely manner.